

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 101

10397

1. PLACE OF DEATH:

County Charles
 City or town Marbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State md. County Charles
 City or town Marbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sue Cole

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 22, 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

4

hrs.

min.

9. Birthplace

Baltimore, md.
(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

MOTHER FATHER

12. Name

Charles Cole

13. Birthplace

Ky.

14. Maiden name

Alice Bowie

15. Birthplace

Marbury, md.

16. Informant

Mrs. Chas. Cole (sister)

Address

Marbury, md.

17.

(Burial, cremation, or removal, which?)

Date thereof

10/23/48
(month) (day) (year)

Cemetery or crematory

Church St. Bury

Location

Marbury, md.

18. Funeral director

Wendell H. Roper
Wendell, md.

Address

19.

Oct. 23, 1948
(Date rec'd by registrar)Mary Swartzland
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 22, 1948 ^{about} 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased

on Oct. 22, 1948and that I saw him on Oct. 22, 1948

Immediate cause of death

Sudden death due to
natural causes, unknown

DURATION

minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

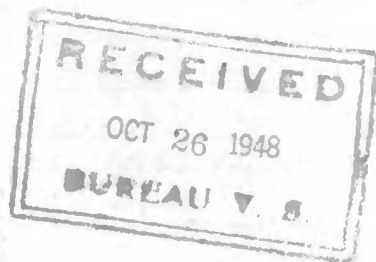
John I. MacKawangh, M.D.
La Plata, Md.

M. D. or other

Address

Date signed 10-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100720

10398

1. PLACE OF DEATH:

County Charles
 City or town offshore Margaretman, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Several hrs.
 Hospital, institution, or street address where death occurred:
Patuxent River
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Prince Georges
 City or town Cong Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Claude Fullerton

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) ABT. 1913 6.(c) If alive, give age _____ years

8. AGE: Years 35 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Garret P.A.
(Town, county, and state)10. Usual occupation Police

11. Industry or business _____

12. Name John Fullerton13. Birthplace Garret P.A.14. Maiden name Vera Sipe15. Birthplace Narrisdale P.A.16. Informant John Fullerton

Address _____

17. Burial Date thereof Nov 8, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Harlem CemeteryLocation Garret P.A.18. Funeral director Arthur E. Simpson Jr.Address 2007- Nichols Ave SE

Nov 8 19 48 Md. District
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 19 48 at 8:30-4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased on Nov. 7, 19 48, to

and that I saw h. in situ on Nov 7, 19 48

Immediate cause of death _____

DURATION

Due to Accidental drowningDue to Boat overturned

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

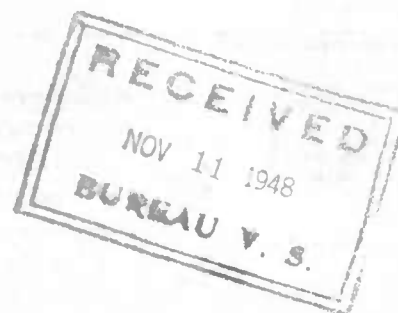
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10-28-48

Where did injury occur? Margaretman, Charles, Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Patuxent RiverMeans of injury Boat overturned Injured at work? NO23. SIGNATURE Dr. L. Makasynski MD M. D. or otherAddress La Playa Md Date signed 11-7-48



[Faint, illegible handwritten text]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10399
105

1. PLACE OF DEATH:

County..... *Charles*
 City or town..... *Wadsworth*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... *md* County..... *Charles*
 City or town..... *Rural Wadsworth*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) if veteran, name war.....

3. (a) FULL NAME

Emma Geppert

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Carl Geppert*7. Birth date of deceased (mo., day, yr.) *June 27, 1874* 6. (c) If alive, give age..... years8. AGE: Years *74* Months *3* Days *29* If less than one day..... hrs. min.9. Birthplace..... *Poland*
(Town, county, and state)10. Usual occupation..... *Housework*

11. Industry or business.....

12. Name..... *Gustave Thomm*13. Birthplace..... *Poland*14. Maiden name..... *unknown*

15. Birthplace.....

16. Informant..... *Carl Geppert*
Address..... *Wadsworth, md.*17. *Burial* Date thereof..... *10/30/48*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... *Washington Nat.*Location..... *Suitland, md.*18. Funeral director..... *Huntt & Ryan*Address..... *Wadsworth, md.*19. *10/29* *48* *W. L. Moore*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10/1/26* 19*48*, at *4:30* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *10/1/16* 19*48*, to *10/12/6* 19*48*, and that I last saw him alive on *10/12/5* 19*48*.

Immediate cause of death.....
Myocardial Collapse
 Due to..... *Cardio-Vas. Wrenal*
 Due to..... *Hypertension*
Obesity
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

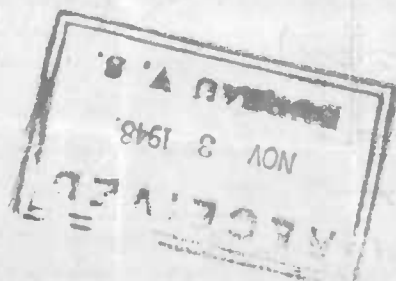
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *W. L. Moore* M. D. or otherAddress..... *Wadsworth, Md.* Date signed..... *10/28/48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10400

Reg. Dist. No. 107

1. PLACE OF DEATH:

County Charles
City or town Riverside
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles
City or town Riverside
(If outside city or town limits, write RURAL and give nearest town)
Street No. 159
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Baby Benson, DORTHY ANN

3. (b) Social Security Number

4. Sex Female 5. Color or race Old 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 23 1948

8. AGE: Years Months Days If less than one day hrs. min. 2

9. Birthplace Riverside Charles Cr. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Walter Carroll

13. Birthplace Riverside, Md.

14. Maiden name Natie Benson

15. Birthplace Riverside, Md.

16. Informant Natie Benson

Address Grayton Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Oct 25 1948
(month) (day) (year)

Cemetery or crematory Oak Grove

Location W. Riverside

18. Funeral director Walter Carroll

Address Riverside Md.

19. Oct. 24 19 48 Nancy J. Southland Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 19 48 at 11 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Prematurity

No Physician in attendance

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature George C. Rickwell M. D. or other

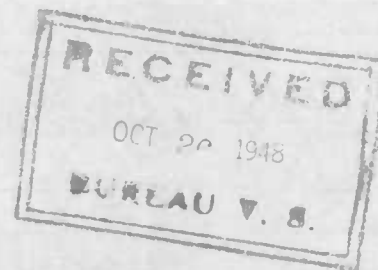
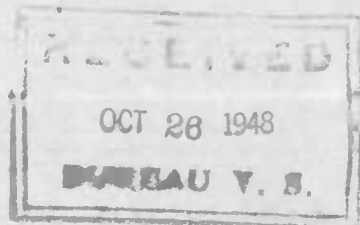
Address Harbury Md. Date signed Oct 24 1948

MARGIN RESERVED FOR BINDING

VS A15

9-46-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inc correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

10401

157d

1. PLACE OF DEATH:

County Charles
 City or town La Plata en route
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? En route
 Hospital, institution, or street address where death occurred:
D.O.A. Physicians Memorial Hospital
 How long in hospital or institution D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Charles
 City or town Waldorf
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Harold Hubbard, Jr.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date at _____
 deceased (mo., day, yr.) March 9, 1948
 8. AGE: Years 0 Months 7 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Sanardtown, St. Mary's, Md.
(Town, county, and state)10. Usual occupation Infant

11. Industry or business _____

12. Name Joseph Harold Hubbard13. Birthplace Indiana14. Maiden name Mary Elizabeth Bowles15. Birthplace Palmers, Md.16. Informant Mr. Mary E. HubbardAddress Waldorf, Md.17. Burial Date thereof Oct 13, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation Buried in18. Funeral director W. E. Mattingly SonsAddress Laurelton, Md.19. 10/12/48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 10:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from onOctober 11, 1948 to October 11, 1948and that I saw him die on October 11, 1948

Immediate cause of death _____

Undetermined accuratelypresumably brain disease

Due to _____

Unknown, presumably congenitalDue to brain anomaly

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John E. McKinnon, M.D. Deputy Medical ExaminerAddress La Plata, Md. Date signed 10-11-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10402

Reg. Dist. No. 101

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Paul Jenkins

3. (b) Social Security Number

4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day.....

16 hrs. min.
 9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereon.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Oct. 28 1948 Mary Southland Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him alive on.....

Immediate cause of death.....

Premature

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

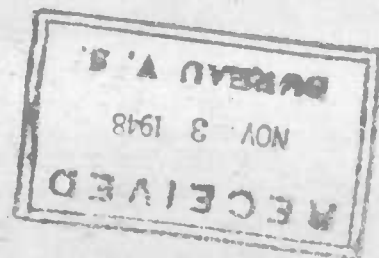
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 106

10403

1. PLACE OF DEATH:

County Charles
 City or town Bryans Road
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 104 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Charles
 City or town Bryans Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Layton Morris

3. (b) Social Security Number

579184360

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Bertie Morris
 6. (c) If alive, give age 44 years
 7. Birth date of deceased (mo., day, yr.) April 8, 1907
 8. AGE: Years 41 Months 6 Days 14 If less than one day
 hrs. min.

9. Birthplace Deerfield Va.
 (Town, county, and state)
 10. Usual occupation Automobile Mechanic
 11. Industry or business Truck Transfer Co.
 12. Name William Thomas Morris
 13. Birthplace Rockingham County Va.
 14. Maiden name Ida M. Rowe
 15. Birthplace Bath County Va.

18. Informant Bertie Morris
 Address Bryans Road, Md.
 17. Burial Date thereof Oct. 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill
 Location Washington D. C.
 18. Funeral director Walsh Funeral Home
 Address 741 11th St. S.E. Wash. D. C.
 19. Oct. 22 48 Odey Price
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1948 at 4P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1948 to Oct. 22 1948
 and that I last saw him alive on October 28 1948
 Immediate cause of death Coronary Embolism
 Due to Acute Myocarditis
 Due to
 Other conditions Chronic Nephritis
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

1 day
4 days
1 yr.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide
 Date of
 Where did injury occur?
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Frank L. Susan
 M. D. or other
 Address Indian Head, Md. Date signed 10-22-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10404

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... Charles
 City or town..... La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 1
 Hospital, institution, or street address where death occurred:
Physicians Memorial Hospital
 How long in hospital or institution?..... 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md. County..... Charles
 City or town..... La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edward W. Robertson

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Single
 6. (b) Name of husband or wife.....
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... March 2, 1857

8. AGE: Years..... 91 Months..... 7 Days..... 7
 If less than one day..... hrs. min.

9. Birthplace..... Charles co. md.
 (Town, county, and state)

10. Usual occupation..... Retired Farmer

11. Industry or business.....

FATHER 12. Name..... John Robertson
 13. Birthplace..... Chas. co. md.

MOTHER 14. Maiden name..... Roberta Wallis
 15. Birthplace..... Montgomery Co. Md.

16. Informant..... Wallace Barnes
 Address..... La Plata, Md.

17. Burial..... Burial Date thereof..... 10/12/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Rest
 Location..... La Plata, Md.

18. Funeral director..... Hunt & Ryan
 Address..... La Plata, Md.

19. 10-12 48 Julius H. Vasey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 9, 19... 48 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... 36 to... Oct. 9, 19... 48
 and that I last saw him alive on... October 8, 19... 48

Immediate cause of death.....
Shock and prolonged vomiting
from fracture of hip.

Due to.....
Osteosarcoma of hip

Other conditions..... Coronary artery disease
Rheumatoid arthritis
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
 Means of injury..... Stumbled but did not fall injured at work?

23. SIGNATURE..... James L. MacKinnon, M.D.
 M. D. or other
 Address..... La Plata, Md. Date signed..... 10-9-48

CERTIFICATE OF DEATH

RECEIVED
OCT 14 1948
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

10405

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

County CasperCity or town La Platan
(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death?

Hospital, institution, or street address where death occurred:

Physicians Memorial HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County CharlesCity or town Newport
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Daniel H. Ryce

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Maudie Wank

7. Birth date of

deceased (mo., day, yr.)

Sept. 10, 1870

8. (c) If alive, give age _____ years

8. AGE:

Years 78

Months _____

Days _____

If less than one day
hrs. _____ min. _____

9. Birthplace

St. Maury Co. Ind.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

James Ryce

12. Name

13. Birthplace

St. Maury

14. Maiden name

15. Birthplace

Wilson W. Ryce

16. Informant

Newport, Ind.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 10-21-48
(month) (day) (year)

Cemetery or crematory

Christ Church

Location

Waples Ind.

18. Funeral director

Address

Hulst + Ryan
Waldorf10-21-48
(Data rec'd by registrar)

19-48

Julian H. Posey
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1948 at 7:20 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 1948 to Oct 18 1948and that I last saw him alive on Oct 18 1948

Immediate cause of death

ShockDue to Fractured hip

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

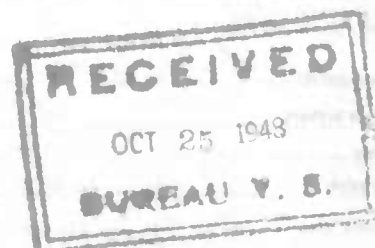
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/15/48Where did injury occur? Newport (City or town) Ind. (County) Home (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Vertebral Fracture getting out of bed. Injured at work?23. SIGNATURE E. Dehelen M.D. or otherAddress La Platan Ind. Date signed 10-18-48

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10406

Reg. Dist. No. 100

1. PLACE OF DEATH: *Charles*
County *Faulkner*
City or town *Faulkner*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *md* County *Charles*
City or town *Faulkner*
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME *Harold Serviss Swann*

3. (b) Social Security Number

4. Sex *M.* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *M.*

6. (b) Name of husband or wife *Elizabeth Swann*

7. Birth date of deceased (mo., day, yr.) *June 11, 1879* 8. (c) If alive, give age years

8. AGE: Years *69* Months *3* Days *25* If less than one day hrs. min.

9. Birthplace *New Jersey*
(Town, county, and state)

10. Usual occupation *Oil Distributor*

11. Industry or business *Retired*

12. Name *Andrew J. Swann*

13. Birthplace *Connecticut*

14. Maiden name *Ann Serviss*

15. Birthplace *New Jersey*

16. Informant *Mrs. Anna Willis*

Address *Faulkner, Md.*

17. *Burial* Date thereof *10/19/48*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Trinity*

Location *Newport, Md.*

18. Funeral director *Ward & Ryan*

Address *Waldorf, Md.*

19. *10-9-48* 19 *Julius H. Pusey*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *10-6-48* at *2:05* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *4-2* 19 *41*, to *10-6* 19 *48*.

and that I last saw him/her alive on *10-6* 19 *48*.

Immediate cause of death *Coronary Occlusion* DURATION *10-6-48*

Due to *arteriosclerosis*

Due to *Dissecting*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

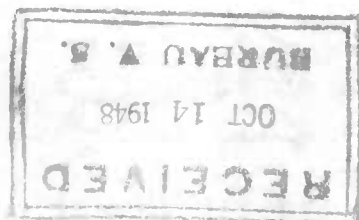
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE *J. Pusey* M. D. or other

Address *La Plata, Md.* Date signed *10-8-48*



Address: Date signed: 11/1/90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

